HCFA WA

HEALTH CARE FOR ALL EDUCATION FUND

Connecticut is Leading the Way: Universal, Publicly-funded Health Care

By Roger Gantz, Member of HCFA-WA Policy Committee

The US is moving forward state by state. There is unique legislation growing in many states. There are commissions and task forces leading the way in Washington, Oregon, and other states. There are powerful actions happening "desde California hasta la isla de Nueva York." Connecticut is leading the way by moving **from managed care organizations to a new model** of a single organization to administer healthcare services. This new model combines the role of a fiscal agent, eligibility/benefit manager, and access/network manager into a program called an **administrative services** organization.

Beginning in the early 1990s, state Medicaid programs began major initiatives to enroll their Medicaid clients into managed care organizations (MCO). Under an MCO model, the contracting health plan is paid a per member month payment for services, and is at financial risk for the services specified in their contract. Among the reasons for the MCO initiatives were to obtain better budget predictability, shifting a portion of financial risk from the state to MCOs, increasing provider participation, and implementing "value-based" payment systems. As of July 2020, all but four states (Alaska, Connecticut, Vermont, and Wyoming) had Medicaid clients enrolled in comprehensive, risk based MCO or primary care case management. Over 70% of all Medicaid clients were enrolled in MCO systems.

Connecticut's Medicaid program, known as HUSKY Health, implemented its MCO initiative in 1995 with 11 health plans. Over time a series of issues resulted in plans leaving HUSKY Health. In 2010, Connecticut abandoned its MCO model. Legislation directed the Department of Social Services to replace its MCO model with an administrative service organization (ASO). **Health ASOs are private contractors that perform one or more functions for governmental health care programs or private sector health insurance coverage**. Under an ASO contract, the contractor (government or business entity) pays a fee to the ASO for functions set forth in the contract. Unlike MCO contracts, the contractor retains all liabilities and risks for the clients or employees. Medicare uses an ASO model, called Medicare Administrative Contractors, to administer its Part A and B fee-for-service components.

The Department of Social Services implemented its HUSKY Health ASO model in 2012. As of 2022, there were **four ASO contractors**:

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Winter

2023

What's inside

Health Care for All - WA advocates for high quality, sustainable, affordable, publicly funded health care

Health Care is a **Human Right**

Health Care for All-WA Newsletter

Winter 2023

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From the President's Desk

by Ronnie Shure, President.

Health Care Reform: To Universal, and… BEYOND

I am not paraphrasing Buzz Lightyear. I am just emphasizing the message from John Santa, a member of the Oregon Joint Task Force on Universal Health Care. When members of Oregon's Task Force shared their final report with the Washington Universal Health Care Commission, Dr. Santa described their robust recommendations as preparing for a moonshot. I remember President Kennedy speaking of moonshots by saying "… we will do this not because it is easy, but because it is hard **…" How can we define the term "universal"** when we talk about improving the US healthcare system? We start by saying **"everybody in, nobody out."**

We start with **financial issues**. We spend much more than other developed countries, so we look at ways to control costs. The US healthcare system is complicated and not very transparent. We are evaluating ways to limit the increases in the cost of hospital visits, specialty care, long-term care, prescription drugs, medical equipment, and health insurance. This is only the first stop on our journey - make health care affordable and prevent the cost from being a burden on our health.

We know that **comprehensive benefits** are needed to maintain our quality of life. We can make it more difficult to maintain a high quality of life when we limit care for mental health, substance use disorders, vision impairment, hearing loss, and dental treatment. We put a high value on reproductive and sexual health benefits. We realize that treatment of children and youth provide important benefits. We must pack our luggage for this journey with the most benefits that we can carry on our voyage.

The **health disparities** in our country have to be addressed. We must address the health impacts of structural and interpersonal racism and protect vulnerable populations against discrimination. We can develop health care services with an equity lens and focus on community-based organizations to lead the way. We will only improve the health of our community if we address the social determinants of health as we move to each stage of our journey on healthcare reform.

The **route to health care reform must include access to** high quality health care. Our society has improved its communication services dramatically, so we have the pathways to provide culturally and linguistically competent services for anyone with disabilities. We must navigate a seamless system to provide everybody with the information and networks to make decisions about our health care. After all, health care is a human right.

Washington state is one of the national leaders in this journey. Join Health Care for All - Washington to help support the actions that will lead to universal health care … and beyond.

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Policy Committee Report

By Sarah K. Weinberg MD, Chair

We effectively prepared for the 2023 Legislative Session during the last quarter of 2022. The Policy Committee helped support the Universal Health Care Commission (UHCC) by arranging a presentation at the December 15th Commission meeting with leaders from the **Oregon Joint Task Force on Universal Health Care.** One of our volunteers, Roger Gantz, was appointed to the UHCC's new **Finance Technical Advisory Committee.** Our lobbyist, Lonnie Johns-Brown, led our Policy Committee to finalize **a budget proviso** to increase funding for the UHCC.

The UHCC devoted the bulk of their December 15th meeting to the presentation by the Oregon Task Force about their Report (see the HCFA Fall Newsletter for a review of this report). We worked closely with the UHCC staff and the leaders from Oregon to identify key points to describe the process by which they generated this report in such a short time – about 2 years. Bruce Goldberg, John Santa, and Daniel Dietz described Oregon's efficiency in organizing their task force, emphasis on health equity, plans for normalization of provider reimbursement, research on administrative savings, and most importantly their emphasis on a robust organization to implement single payer financing in their state. We played a vital role in supporting this presentation, and we know it had a strong impact on the UHCC.

The other piece of business at the UHCC meeting was the appointment of 9 people to the Finance Technical Advisory Committee (FTAC), which will meet for the first time on January 12, 2023. We recommended one of our volunteers, Roger Gantz, and we were proud to see him appointed. The FTAC will be expected to do a lot of work: some 23 areas to explore in developing a unified system, including program eligibility, benefit and cost-sharing design options, methods for including Medicare beneficiaries and ERISA -protected employees, administrative reduction options, and financial modeling of various design and revenue options.

We will be advocating for expanding the funding for the UHCC from $736,000 to $1,243,000. If the FTAC is to do its work it will need more staff support (1.0 FTE) as well as more funds for professional services contracts to do the needed actuarial and financing studies. Our lobbyist is working with Senators and Representatives to develop a budget proviso to expand funding for the UHCC. We will need your help when budget issues come up in the Appropriations Committee and the Ways and Means Committee. Please watch for our action alerts if your legislators are members of those committees.

We have been working with our health care allies in planning for the coming 2023 Legislative Session (starting Jan. 9). We will alert you as each of these groups publish their legislative agendas. There are important bills being drafted to support the Sec. 1332 (of the ACA) waiver to provide coverage for immigrants, fix the Medicare affordability "cliff", and expand dental therapy. At our Annual Meeting on December 3rd, there were five legislators giving us "A Quick Look at the 2023 Legislative Session" and you can see that video on our website on the page for "Current Legislation".

2023 Legislature Expected Schedule A draft of the expected schedules for various committees in calendar form can be found on the legislature's website, www.leg.wa.gov under House or Senate Agendas, Schedules and Calendars. Of course, if you're on our HCFA-WA email list, you'll be getting updates and opportunities for contacting your legislators as the session moves along. Stay tuned!

Pro tip: For easy access to these links, view this Newsletter by clicking on "The Latest" tab at the top of the homepage where you'll find this issue as well as previous ones: https://www.healthcareforallwa.org/the_latest

Questions? Suggestions? Let us know:
communications@healthcareforallwa.org

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Communications Committee *Continued from p 4*

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Fundraising and Outreach Committee Report

By Peter Lucas, MD,, Chair

Happy New Year to all our supporters! We thank you for your interest and donations in 2022.

The year ended with our Annual Meeting (Dec. 3) which, in addition to being an educational and administrative event, is also one of our major fundraising opportunities. Once again, our board members made substantial pledges that were matched by meeting attendees and others who were unable to attend.

There are several things in the works for 2023. In addition to the GiveBIG campaign in the spring and the Annual Meeting in the fall, we will continue to fundraise during our monthly 2nd Wednesday webinars and will encourage recurring monthly donations every chance we get. These are especially appreciated and helpful. We also hope to have more in-person events where we will both educate and solicit donations.

The Fundraising and Outreach Committees have now merged since their functions overlap considerably. We expect this approach will better raise awareness of our cause and bring in more volunteers and supporters. One of our first actions is a plan to use QR codes, liberally disseminated throughout the state via media, bulletin boards, and lampposts, to direct new folks to our website. Accompanying the QR codes will be pithy and compelling statements designed to grab attention and stimulate interest. We expect to reach many Washington residents in this manner and to recruit more supporters to universal health care. We will report on the effectiveness of this strategy in the next newsletter. If you would like to participate, please contact us and we will send you some stickers that you can post in your community.

Your support of HCFA-WA funds our lobbyist who is hard at work in Olympia advocating for us and you. You can read about our legislative agenda in the Policy Committee Report in this newsletter and on our website.

Have a healthy and productive 2023!

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Communications Committee Report

By Marcia Stedman & Consuelo Echeverria, Co-Chairs

New Year, New Website

HCFA-WA's new and improved website is now live for your viewing pleasure https://www.healthcareforallwa.org/ This team effort was led by Consuelo Echeverria, co-chair of the Communications Committee, along with Communications Specialist Sydnie Jones and team members Connie Rock, Ron Lovell, and Marcia Stedman. We greatly appreciate everyone's active participation and dedication to this project.
Our new site has:

- New graphics of HCFA-WA at work
- New sign-up and volunteer forms so you can best utilize your skills to promote universal health care!
- New language on many pages
    - ◊ Home page
    - ◊ About Us
    - ◊ Legislation
- New sections
    - ◊ Universal Health Care Commission
    - ◊ The Latest with easy access to our publications and blog
    - ◊ Events with a calendar so you can track not only our events but events from our partner organizations as well as Universal Health Care Commission meetings. Check in regularly so you don't miss a thing!
- Enhanced navigation with a full site map at the foot of each page
- Quick links to our social media platforms

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Connecticut is Leading the Way

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Community Health Network of Connecticut (medical services); BeneCare Dental Plans (dental services); Beacon Health Options (behavioral health services), and MTM-Veyo (non-emergent medical transportation services). The four ASOs are responsible for member engagement services including assisting HUSKY beneficiaries with questions on eligibility and benefit coverage, referrals to other ASOs for the services they are contracted to administer, prior authorizations for services, and provider network management, including sufficient access to services for beneficiaries.

Gainwell Technologies is HUSKY Health's **Fiscal Agent**. It is responsible for processing and paying claims, provider enrollment and training, provider call center to assisting providers with billing questions; and providing pharmacy prior authorization service and call center.

It should be noted that while they may contract out a number of administrative functions, federal law requires states, as the state Medicaid agency, to establish program eligibility rules for eligibility groups defined in federal rules and authorized by the state legislature. Federal law prescribes a set of mandatory services that each state's Medicaid program must provide, and a set of so-called optional services and waiver services. States prescribe the optional and waiver services that will be offered to Medicaid and CHIP beneficiaries. As the state Medicaid agency, DSS is responsible for the rules governing the amount, scope, and duration of these benefits. This includes the prior authorization standards that the ASOs use in their contracted utilization management functions.

To date, there has not been an evaluation of Connecticut's Medicaid ASO model compared with other states Medicaid MCO models. However, there is some public information on the ASO model's cost, quality, and access. A 2016 Harvard Law School's Center for Health Law & Policy Innovation review of Connecticut and two other innovative states reported that **provider participation had improved**. The Department of Social Services reported improvement in key health indicators under its ASO model and the Center for Medicare and Medicaid Services "Medicaid & CHIP Score Card" indicated that Connecticut was **above average across 16 of 20 health indicators and ranked very high across a number of children's 2020 health measures**. While comparison of more recent cost-containment is not available, a 2017 Health Affairs article indicated that Connecticut's Medicaid program was a national leader in controlling per-capita cost trends during a 2010-14 period.

We can expand health care to more and more people as we reduce the cost of administration. We can reduce the burden on healthcare providers by creating a single, publicly-funded payment system. We can focus on improving health outcomes and overcoming health disparities. **We can learn from programs that are successful in other states**

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Medicare Patients Needing Complex Cancer Surgery Fare Worse in Medicare Advantage Plans

By Sarah K. Weinberg MD, editor

A recent article in the Journal of Clinical Oncology compared the outcomes for patients needing complex cancer surgery, like liver, pancreas, and stomach cancers, between patients in Medicare Advantage plans (MA) and those in Traditional Medicare (TM). The main finding was that TM patients had less delay from diagnosis to treatment, and that they were more likely to be treated in hospitals with high levels of experience with these operations.

MA patients, through prior authorization limitations, were diverted away from these hospitals, and had worse 30-day mortality results. The MA plans spent less on care for these patients than was spent by Traditional Medicare, but, apparently, at a cost of worse care as measured by the ratio of deaths by 30 days post-op. This is another reminder of the inferiority of a health care system focused on profits and cutting costs, as compared with one focused on supporting the physician -patient relationship and decision-making.

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Bergman OpEd

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future, as the public and political leaders are unaware of the seriousness of the problem. Also, as in the "robber-baron" era of the late 1800s, there are no constraints inhibiting health corporations from earning profits by curtailing access.

Dr. Bergman does make two suggestions for improvement:

1. Greatly increase the number of nurses at all levels of training, which will require substantial improvement in pay.
2. Use the National Health Service Corps physicians. This program, started in 1972, assigns primary care doctors to practice in "underserved" rural and urban areas. In return, the doctors' student loan debts are erased

Traditional Medicare vs Medicare Advantage

By Sarah K. Weinberg MD, Editor

In the Fall 2022 issue of this newsletter, there was a review of a NY Times article about serious abuse of the Medicare Trust Fund by private Medicare Advantage (MA) insurers. This article is to explain the difference between the two choices Medicare enrollees face each year at "open enrollment" time. An important first note: ALL Medicare enrollees must pay monthly Part B premiums, usually deducted from their Social Security checks. (Part B covers outpatient provider bills.) Medicare Part A covers hospital bills, and there is no monthly premium. It's funded by the Medicare Trust Fund from payroll taxes paid by employers and employees during their working years.

Access to providers – In Traditional Medicare (TM) enrollees can go to any licensed provider who accepts Medicare, the vast majority of physicians and hospitals in the U.S. Enrollees in a MA plan are restricted to the providers in the plan's network, which can be quite narrow.
Managed care – Nearly all MA plans require a referral from a plan primary care provider for access to specialists, tests, or other procedures. Prior authorizations, at the very least, involve delays in obtaining treatment.
Covered benefits – Generally, MA plans offer additional benefits beyond those required in TM, such as prescription drugs and eyeglasses. MA plans also commonly offer attractive things like gym memberships, and their monthly fees are either $0 or quite low. A major deficiency in TM is that it only covers 80% of provider fees, leaving 20%, with no out-of-pocket limit, for the enrollee to pay. Many, if not most, TM enrollees also purchase Medigap policies to cover the 20% co-insurance and prescription drugs.
Quality of care – Results of studies are mixed. MA plans mostly do better at preventive care and avoiding unnecessary hospital admissions. But TM works better when patients need more care and specialist care in particular. (See the article in this issue about patients needing serious cancer surgery.) There is also at least one study that shows that enrollees in their last year of life disenroll from MA to TM in much greater numbers than the reverse.

In summary: It's not an easy choice, depending on one's other resources and health status.

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Letter to the Editor New York Times

By Sarah K. Weinberg MD, Editor

To the Editor:

Re: "A Rural Hospital's Excruciating Choice" 12/9/22

The underlying problem here is that the U.S. is using the wrong model for our health care non-system. Instead of running it as a bunch of capitalist businesses with no coordination, our country needs to do what the rest of the developed world does: run the health care system as a public service financed by taxes and overseen by the government.

Rural hospitals would then become a national responsibility, and there would be an agency responsible for making sure there are adequate facilities spread across the nation to provide needed care to the people who live in each community, whether large and urban or small and rural. Canada is geographically most similar to the U.S., with several large urban areas and a vast rural spread with much smaller towns. Since Canada adopted a public service model, started in 1947 in Saskatchewan and finalized nationally in about 1984, they have provided good health care throughout without excessive cost increases over the years.

Again, the fundamental need is to view our health care system as a public service, not as a profit-making entity. (Even our mega-hospitals that are technically "non-profit" are accumulating enormous "reserves" and paying obscenely high salaries to their top officers.)

(Note: I am a retired pediatrician, and a long-time member of Physicians for a National Health Program – now President of its Washington chapter.)

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Join Now for 2023!
Health Care for All – Washington

Yes, I'll join to work for high quality, sustainable, affordable, publicly-funded health care for ALL Washington residents

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$_____Contributions to **HCFA Education Fund,** a 501(c)3, are tax deductible.

$_____Contributions to **Health Care For All-WA,** a 501(c)4, go for vital organizational growth, but are **not** tax deductible.

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Thank you for your support.

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Review: "Our fraying health care system is reaching a breaking point" Dr. Abe Bergman OpEd in the Seattle Times 1/2/23

By Sarah K. Weinberg MD, editor

(Editor's Note: Dr. Bergman, now 89, is professor emeritus of pediatrics at the University of Washington. He was an attending physician when I was a pediatric resident at Children's Hospital in Seattle, 1978-81).

Dr. Bergman focuses mostly on the lack of an adequate supply of primary care physicians in the U.S., making it difficult to get an appointment when needed. (Ed. Note: I called to make my annual Medicare wellness exam with my primary care physician just before the New Year. The first available appointment: Saturday, March 28. I took it.) He cites several reasons for this shortage, not all of which are limited to the U.S.:

- Quitting primary care office practice. Often this is from job dissatisfaction as a result of practice managers scheduling too many patients into one day. The flooding of the system by COVID-19 patients added even more stress.
- Not taking night/weekend call, meaning that all urgent matters after office hours must be taken to an Urgent Care Clinic or an Emergency Room.
- Takeover of most components of health care, including hospitals, physician practices and pharmacies by large corporations. These corporate owners are interested only in maximizing profits and cutting costs.
- Change of focus from the physician-patient relationship to health care as a "commodity" to be "delivered" to "consumers" by "providers". Not to mention grading physicians on their "productivity".

.Even "non-profits" like the Providence system (owns Swedish Hospital in Seattle) invest billions in hedge funds and pay 8-figure annual salaries to their CEOs.

Dr. Bergman doesn't think this situation will improve, at least in the near

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Health Care for All-Washington

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NHS Price Problem is Big Pharma, Not Striking Nurses

https://consortiumnews.com/2022/12/23/nhs-cost-problem-is-big-pharma-not-striking-nurses/

Not all is quiet on the Western front, however. In its search for ever-greater profits, Big Pharma is strangling healthcare in richer countries too. The same monopoly pricing and trading mechanisms that keep those in the Global South from accessing care are eating up access in the Global North too.

Between 2011 and 2017, the cost of medicines for NHS England grew from £13bn to £17.4bn — a 5 percent rise every year. In 2020, this reached £20.9 billion. Yet the government is currently considering trade arrangements, leaked documents show, that will increase this cost even further by forcing the NHS to buy from pharmaceutical monopolies instead of buying generic medicines.

By contrast, the U.S. pharmaceutical giant Pfizer recorded profits of $21 billion last year. That amount could fund the nurses' wage demand twice over — while also bringing in more revenue, through tax and spending, than corporate profits do. That should put the nurses' demands in perspective. It's not striking health workers who are holding the NHS at gunpoint — it's the corporate compulsion to squeeze and extract**.**

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